

PETROLEUM STORAGE TANK RELEASE TRUST FUND

REQUEST FOR REIMBURSEMENT FORM

KDHE RFR#

Office Use Only

You must have applied and been admitted to the Trust Fund and signed a Consent Agreement with KDHE before requesting reimbursement for corrective action expenses. All corrective action procedures and costs must be pre-approved in writing by KDHE Trust Fund Staff.

INSTRUCTIONS

1. All blanks must be completed
2. If an item doesn't apply, write "N/A"
3. Use the correct KDHE Site Code and Name.
4. All invoices must be in the correct KDHE format
5. An extra copy of this form and all supporting documentation must be submitted.
6. If canceled checks are being submitted as proof of payment, two front and back copies must be submitted.
7. Time sheets for field work must accompany applicable invoices. (Monitoring and OMM field work excluded)
When required, they must be signed by the consultant and the owner/operator.
8. Please print neatly or type.
9. Sign and date this form in Section 3.

SECTION 1. OWNER/OPERATOR AND SITE INFORMATION

- A. KDHE Site Code: Site Name: _____
- B. Owner/Operator Name: _____ Daytime Phone Number: (____) _____
(Name of person or business to appear on the reimbursement check)
- C. Mailing Address: _____
(Address to which check will be sent) (City) (State) (Zip)
- D. Name of Co-payee: _____
(Name of consultant performing corrective action work - if applicable)
- E. If this is being submitted by the consultant as the Attorney in Fact for the applicant, check here: ☐

SECTION 2. REIMBURSEMENT INFORMATION

1. DATE OF INVOICE: List the invoices separately and in chronological order.
2. INVOICE NUMBER: The number of the invoice, if available.
3. AMOUNT REQUESTED: The amount you are requesting from each invoice.
4. CANCELED CHECK NUMBER: If the invoice has been paid, provide the number of your canceled check.
5. TOTAL AMOUNT: The total amount requested for all invoices.

(1) Date of Invoice	(2) Invoice Number	(3) Amount Requested	(4) Canceled Check No.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
(5) Total Amount Requested: _____			

SECTION 3. AUTHORIZATION

I certify that, to the best of my knowledge, the amount of reimbursement requested reflects actual corrective action conducted at the site shown in Section 1 of this form. I understand that knowingly submitting false information to obtain reimbursement from the Petroleum Storage Tank Release Trust Fund may result in criminal prosecution.

(Print or Type Applicant's Name)

(Applicant's Signature)

(Date)

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Page 2

WHERE TO MAIL YOUR REQUEST:

Kansas Department of Health & Environment
Bureau of Environmental Remediation
Storage Tank Section
1000 SW Jackson - Suite 410
Topeka KS 66612-1367

CHECK LIST

_____ All Blanks Completed	_____ Front & Back Copies of Canceled Checks (When required)
_____ Two Copies of Everything	_____ Time Sheets Attached (When required)
_____ Invoices Attached	_____ Form is Signed and dated

NEED ASSISTANCE?

CALL:

(785)296-1678

INCOMPLETE REQUESTS WILL BE RETURNED

(This page is informational only. If this request is in two page format, only the first page needs to be submitted to KDHE.)